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Abstract
Objective: Molar pregnancy is classified as one of the diseases groups as a type of Gestational Trophoblastic Disease (GTD) which is emerged from placenta. Hydatidiform moles are diagnosed one per 1500-2000 pregnancies in the United States. There seems to be a large variation in mole development and its frequency in Far East Asia is higher than western industrial. Mole is divided into two types, complete and partial. Our aim is compare Clinical Presentation complete Molar Pregnancy and partial Molar Pregnancy in Imam Reza Teaching Hospital in years 2006-2018.

Methods: Over a period of ten years, 289 patients with Clinical Presentation of Molar Pregnancy referred to Imam Reza Teaching Hospital in Kermanshah were examined. The study results are based on sonography, physical examination, pathology report and test taken of patient. Analysis was performed using sp, ss version 16 computer software. T test, chi square, Wilcoxon test. P-value less than 0.05 level of significance was considered statistically significant.

Results: In this study, most molar pregnant were in the 25-45 age groups as it is the age of fertility power, followed by 15-24 age range in the second rank; on the other hand, partial mole was highest frequency in 15-24 years old age. In the present study, 114 pregnant (48.1%) women were nullipar and 123 (51.9%) were multipar. the size of uterus in complete molar pregnancy were larger than partial mole. In this study only the uterus size which had significant statistics relation with molar pregnancy (P=0.017) and was not found significant relationship between other variables in our study and molar pregnancy.

Conclusion: Given the significance of uterine size and its importance should be considered in future studies. And seen as an approved feature

Keywords: Molar pregnancy; Clinical Presentation; Full Molar.

Introduction
Molar pregnancy is classified as one of the diseases groups as a type of Gestational Trophoblastic Disease (GTD) which is emerged from placenta¹². Hydatidiform moles are diagnosed one per 1500-2000 pregnancies in the United States. There seems to be a large variation in mole development and its frequency in Far East Asia is higher than western industrial countries¹³.

Mole is divided into two types, complete and partial. Molar pregnancy occurs when there are specific abnormalities in the fertilized eggs. The fertilized egg either does not develop into an embryo (complete) and/or, it grows in an abnormal form and does not survive (partial). In most complete molar pregnancies, the mother’s chromosomes do not exist in the fertilized eggs and the father chromosomes replicate. Therefore, there are two copies of father’s chromosomes in the egg and no chromosomes are found of mother in it.
In this status, there is no embryo, embryo sac or any normal placental tissues; instead, the placenta develops a tumor of cluster sacs[8].

Hydatiform Mole is found in 1 to 2 cases per 1000 pregnancies in Japan and China and the highest frequencies are found in Indonesia, India and Turkey with 12 per 1000 pregnancies[5]. The frequency of 0.5 to 1 per 1000 pregnancies[9]. The symptoms of the disease usually appear at the end of the first trimester and during the second trimester. The clinical symptoms include vaginal bleeding (97%) in past; 84% present; anemia (50%), excessive enlargement of uterus, as one of the classic symptoms of complete mole (50%), no fetus heartbeat, preeclampsia (27%), Hyperemesis during pregnancy (25%), trophoblastic emboli (2%), ovarian theca-lutein cysts (50%), thyrotoxicose (2%).

Based on the studies, high level of HCG in molar pregnancy patients might lead to hyperthyroidism[6,7] which is reported in 7% of cases. In some studies; however, this figure is reported 5%[8], preeclampsia has been reported in 27% of cases and one per 74 pregnancies[9].

If this disease is diagnosed Suction curettage and Evacuation of uterus is performed immediately. Following the curettage, the β-HCG level of blood is measured weekly. In a person whose β-HCG is reduced, the follow up and measuring the hormone level must be continued for at least 6 months; however, if serum B-HCG level is plateau or increased persistent gestational trophoblastic disease or tumor is diagnosed. The aim of this research is Compare clinical Presentation of complete Molar Pregnancy and partial Molar Pregnancy.

Materials and methods

Demographic information and history of the disease were obtained through a data collection form designed by the presenter. This was a retrospective analytic descriptive study carried out on the cases of molar pregnancies with Clinical Presentation of Molar Pregnancy, who admitted at the department of gynecology in Imam Reza teaching hospital study during 10 years (2006-2018). It was approved by Imam Reza Hospital Clinical Research development unit. 38 files were reported with the final pathology diagnosis including pregnancy products, abortion, and by conformity with sonography and pathology results, those cases were eliminated and ultimately, total 237 files were studied by the initial and final diagnosis of molar pregnancy. In this study Mother’s age, Gravidity, Parity ,Residence area, History of hydatitiform mole, Hyperemesis , Pre-eclampsia ,Trophoblastic emboli based on medical history registry, Mole type Hydatitiform, gestational age, Teha. Lutein cysts According to sonography findings, Level of Initial β HCG, Initial Hb level, Hyperthyroidism, Rh type, Blood type Based on blood test taken for patient, Vaginal bleeding, Uterus size Via physical examination or as registered in the medical file and Pathologic results through pathology report were investigated. Thus, our assessments and grouping into two classes of complete and partial mo-

<table>
<thead>
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<th>Type of molar pregnancy</th>
<th>Age (year)</th>
<th>Gravidity</th>
<th>Gestational age (week)</th>
<th>Uterus size</th>
<th>Level of Initial βHCG (mIU/ml )</th>
<th>Hb level (g/dL)</th>
</tr>
</thead>
<tbody>
<tr>
<td>complete molar pregnancy</td>
<td>Number</td>
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<td>181</td>
<td>181</td>
<td>14.04</td>
<td>11.975</td>
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<tr>
<td></td>
<td>mean</td>
<td>28.54</td>
<td>2.5</td>
<td>11.25</td>
<td>52565.1</td>
<td>11.75</td>
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<tr>
<td>Partial molar pregnancy</td>
<td>Number</td>
<td>56</td>
<td>56</td>
<td>56</td>
<td>13.07</td>
<td>60199.23</td>
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<tr>
<td></td>
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<td>2.23</td>
<td>10.75</td>
<td>56</td>
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<td>237</td>
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</tr>
<tr>
<td></td>
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<td>27.93</td>
<td>2.43</td>
<td>11.14</td>
<td>237</td>
<td>12.024</td>
</tr>
</tbody>
</table>
Excessive normal uterine size is a feature of molar pregnancy. In seen in 61.2% of the cases and was not statistically significant. In our study, vaginal bleeding was 5% of patients had amenorrhea. In the Fatima M study, the most common clinical manifestations of these patients were vaginal bleeding. In the Nirmala and colleagues study, uterus size was greater than gestational age in 18 cases. In our study, the most common symptom in the study population was uterine over-age (75%).

In the vakilis study, 9.3% of patients had hemoglobin levels below 10 g / dl. In the study of Bahasadri, anemia occurred in 13.9%[10], in the study of Zia, anemia was reported at 19.2%. In the study of Abd et al., Which reported anemia in hemoglobin less than 11 g / dl, 24% of patients were anemic. In the present study, only 9.3% of people had anemia at the beginning of pregnancy. In the Bahasadri’s Study, hyperthyroidism was diagnosed in 4.3%. In the Zia study; hyperthyroidism was seen in 19.2%.

Conclusion

Clinical protests were similar to mole partial molar pregnancy and there was no statistically significant difference. Hyperemesis were complete moles rather than partial moles that could be the difference between the differential clinical evaluation molar pregnancies. The aim is to demonstrate the importance of uterine size, access to comprehensive information on the incidence of hydatidiform mole and its associated symptoms in women referred to the Imam Reza Hospital, the western referral center of the country, and the results will be based on future studies.

Conflict of Interests: The authors declare that there is no conflict of interests regarding the publication of this paper.

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